Overview

The Centers for Medicare & Medicaid Services (CMS) is announcing a five-year "Rural Community Hospital Demonstration Program" as mandated under section 410A of the Medicare Modernization Act. Congress included this provision in the law in response to financial concerns of small, rural hospitals that are too large to qualify as Critical Access Hospitals (CAHs). The demonstration will test the feasibility and advisability of reasonable cost reimbursement for small rural hospitals. Fourteen small rural hospitals in eight sparsely populated States were selected to participate. The demonstration is aimed at increasing the capability of the selected rural hospitals to meet the needs of their service areas. CMS will conduct an evaluation of the demonstration.

Eligibility

The following eligibility requirements had to be met for a hospital to be considered for participation in the demonstration. These requirements are specified in the authorizing legislation. An applicant had to be a hospital that:

- Is located in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)) or treated as being so located pursuant to section 1886(d)(8)(E) of the Act (42 U.S.C. 1395ww(d)(8)(E)));
- Has fewer than 51 acute care beds, as reported in its most recent cost report;
- Makes available 24-hour emergency care services; and
- Is not eligible for CAH designation, or has not been designated a CAH under section 1820 of the Social Security Act.

The authorizing legislation requires that the demonstration be conducted in States with low population densities, as determined by the Secretary. For this demonstration, hospitals had to be located in one of the ten least densely populated States: Alaska, Idaho, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Utah, or Wyoming.

Demonstration Payment Methodology

Hospitals selected for participation in the demonstration will receive payment for inpatient services, with the exclusion of services furnished in a psychiatric or rehabilitation unit that is a distinct part of the hospital, using the following rules:

1. Reasonable cost for covered inpatient services, for discharges occurring in the first cost reporting period on or after the implementation of the program;
2. The lesser amount of reasonable cost or a target amount in subsequent cost report periods. The target amount in the second cost reporting period is defined as the reasonable costs of providing covered inpatient hospital services in the first cost reporting period, increased by the inpatient prospective payment update factor (as defined in section 1886(b)(3)(B)) for that particular cost reporting period. The target amount in subsequent cost reporting periods is defined as the preceding cost reporting period's target amount increased by the inpatient prospective payment update factor (as defined in section 1886(b)(3)(B)) for that particular cost reporting period.

For participating hospitals, this payment change will begin with cost report periods beginning on or after October 1, 2004.

(See downloads below for more information: Hospital Approved for the Demonstration, Application Process, Federal Register, & Addendum).